HSE PUBLIC HEALTH

Health Inequalities Position Paper 2025

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Abbreviations

ACE	Adverse Childhood Experiences
CSO	Central Statistics Office
ESRI	Economic and Social Research Institute
HIA	Health Impact Assessment
HiAP	Health in All Policies
HSE	Health Service Executive
LCDC	Local Community Development Committees
NWCI	National Women’s Council of Ireland
PBI	Place Based Initiatives
PBRA	Population Based Resource Allocation
SDH	Social Determinants of Health
TCD	Trinity College Dublin
WHO	World Health Organization

Glossary

Adverse Childhood Experiences (ACE)	Adverse Childhood Experiences (ACE) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life. Such experiences include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence.
Determinants of health	World Health Organization (WHO) definition: factors that combine to affect the health of individuals and communities. Determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviours.[1]
Dimensions of inequality/ equity stratifiers	Criteria upon which population subgroups are grouped or categorised for measuring and monitoring inequalities.[1] Commonly referenced equity stratifiers are summarised in the acronym PROGRESS-PLUS.[2]
Health Atlas	Health Atlas Ireland integrates geographic information systems, database and statistical components with a user-friendly interface that supports web-enabled access across the Irish health sector and collaborating agencies.[3]
Health equity	Absence of unfair, avoidable or remediable differences in health among population subgroups defined socially, economically, demographically or geographically.[1] Health equity is both a process and an outcome of addressing health inequalities.
Health inequality	Measured difference in health between population subgroups. For the past three decades, the term has been used globally to refer to health differences associated with social advantage and disadvantage.[1]
Health inequity	Unfair, avoidable or remediable differences in health among groups of people. In some cases, the absence of a difference between groups (i.e. a situation of apparent equality) might be considered inequitable. Health inequity is rooted in the unfair distribution of, and unfair access to, power, wealth and other social resources, and is linked to forms of disadvantage that are socially produced, such as poverty, discrimination and lack of access to services or goods.[1]
Place based approaches / initiatives / interventions / partnerships	Place based initiatives (PBI) are collaborative community focused strategies that aim to improve health outcomes in a defined geographic area, recognising that health is influenced by the social, economic and environmental factors specific to the place, with a focus on local needs, local solutions, attributes of a place, involving multiple agencies and local communities.[4]

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[1] World Health Organization. Health inequality monitoring: harnessing data to advance health equity. 2024

[2] Cochrane Methods Equity. PROGRESS-Plus PROGRESS stands for Place of residence, Race (or ethnicity), Occupation, Gender (or sex), Religion, Education, Socioeconomic status and Social capital. PLUS includes personal characteristics, relationship features and time-specific stratifiers such as age, disability and sexual orientation.

[3] Johnson H, McIntyre M. Health Atlas Ireland. Dublin, Ireland: National University of Ireland, Maynooth. 2007

[4] McGowan V, Buckner S, Mead R, McGill E, Ronzi S, Beyer F, et al. Examining the effectiveness of place-based interventions to improve public health and reduce health inequalities: an umbrella review. BMC public health. 2021

Local Community Development Committees (LCDCs)	LCDCs are statutory bodies established under the Local Government Reform Act 2014. They aim to coordinate, plan, and oversee local development and community initiatives at the county or city level.[5]
Population Based Resource Allocation (PBRA)	The Department of Health defines PBRA as a funding model for health and social care planning that seeks to equitably distribute available healthcare resources according to population need to promote allocative efficiency and equity in both health outcomes and distribution of resources.
Public Sector Equality and Human Rights Duty	Section 42 of the Irish Human Rights and Equality Commission Act 2014, known as the Public Sector Equality and Human Rights Duty, is a statutory obligation for all public bodies in Ireland to have regard to the need to eliminate discrimination, promote equality of opportunity and protect the human rights of staff and people availing of their services.[6]
Social determinants of health (SDH)	The conditions in which people are born, grow, work, live and age, and people's access to power, money and resources.[1]
Universalism	Universal approaches to reduce health inequalities involve implementing policies and interventions that aim to benefit the entire population, regardless of socioeconomic or demographic differences. Targeted approaches focuses resources and interventions on specific population groups. Blended approaches, such as *proportionate universalism*[7] (the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need) or *progressive universalism*, (an approach to reaching universal health coverage that ensures disadvantaged populations realise equal or greater gains until the goal of universalism is eventually approached), combine universal measures with additional support scaled to the level of need to balance equity and efficiency.[8]
Universal Health Care	The vision of Sláintecare is to achieve a universal single-tier health and social care system, where everyone has equitable access to services based on need, and not ability to pay.

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[5] Government of Ireland. The Local Government Reform Act 2014. 2014

[6] Government of Ireland. Irish Human Rights and Equality Commission Act 2014. 2014

[7] Fair Society, Healthy Lives: The Strategic Review of Health Inequalities in England post-2010 (The Marmot Review).

[8] National Collaborating Centre for Determinants of Health. Let's talk: Universal and targeted approaches to health equity. National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2013

Foreword

This HSE Public Health position paper on health inequalities was requested by the Chief Clinical Officer and the National Director of Public Health. It was developed by a working group comprised of representatives from across the domains of Public Health in the HSE at regional and national levels, working with colleagues from the Office of Wellbeing, Equality, Climate and the National Social Inclusion Office, led by the office of the Director of National Health Improvement - Public Health (see Appendix A).

The group was asked to develop a paper to inform future work within the HSE and contribute to the national Public Health strategy currently under development. To this end the paper considers specific roles and actions for the HSE, and Public Health in particular, in reducing health inequalities in Ireland.

Executive Summary

Health inequalities are experienced by a large proportion of the population in Ireland across their life course. They result from a person's position in society and reflect the effects of poverty, social class, gender, ethnicity and discrimination, and the differential exposures that affect a person's ability to live a healthy life which can be material and psychosocial. The conditions in which we are born, grow, live, learn, work and age (determinants of health) are the most significant influences on our health. Marginalised and socially excluded groups experience health inequalities more intensely and as a result have worse health outcomes.

There is international recognition of worsening health inequalities within and between countries, linked to the COVID-19 pandemic, climate change and conflict, and inadequate progress on the determinants of health and the structural factors that influence these. Health inequalities experienced by children often stem from the social determinants of health (SDH). This includes the material impacts of poverty such as inadequate housing and food insecurity. These factors have lasting impacts on physical and mental health, reinforcing cycles of disadvantage throughout life. There is growing evidence that demonstrates the return on investment for interventions that improve population health and address inequalities.

Existing Irish health policies, Sláintecare and Healthy Ireland, explicitly target the reduction of health inequalities (1,2). However, Ireland to date has not followed other European nations in developing an overarching health inequalities strategy. Following the COVID-19 pandemic and considerable structural reform within the health system, HSE Public Health now has a strengthened mandate:

- address health inequalities;
- advocate for strategies, work programmes and policies that will reduce them;
- work with communities and representative organisations on the issue.

Partnership and collaboration are essential for effective and sustainable action on health inequalities. This includes an embedded approach to community and citizen participation and partnership in future work and a strategy which can give a platform to people experiencing health inequalities. The World Health Organization (WHO) recognises social participation as a key action in addressing health inequalities (3).

Data and evidence are vital to provide the required information to describe health inequalities and their impact, and to assess the effectiveness of policies and interventions aimed at reducing them. Public Health plays a central role in leveraging data to identify and report on health inequalities. This requires collaboration with partners both within the health system, and in other sectors considering the impact of the wider determinants of health.

Inequalities in access to healthcare and other services, along with differences in the experience and quality of healthcare, contribute to unequal health outcomes across Ireland (4). This is of particular relevance in the context of a two-tier private and public healthcare system, where disparities in access to care vary by health insurance status and ability to pay. Ireland remains a relative outlier by European standards in the extent to which differences in healthcare access exist between public and private patients (5).

There is also evidence of discrimination and stigma for population groups accessing care based on characteristics such as ethnicity, disability and migration status (6,7). Reducing such discrimination and providing equitable care aligns with the policy goal of Sláintecare to achieve universal healthcare, and with equality legislation such as the Public Sector Equality and Human Rights Duty that requires public bodies to promote equality, prevent discrimination and protect human rights. Public Health has a role in identifying the unmet needs of those with poorer access to, and outcomes from, healthcare and in ensuring that the HSE delivers a more equitable service for all.

This paper contains key messages on the current state of health inequalities in Ireland along with specific recommendations. These should form the basis of HSE Public Health work in health inequalities in the coming years. Summarised below are the recommendations found within each section of the paper under the following headings:

Policy

Measurement and Monitoring

Communities and Settings

Access and Healthcare

Leadership and Communication

Evidence, Quality and Action

Recommended actions on:

Policy

1. Provide consistent systematic Public Health input into policy at national and regional levels. This includes adopting robust processes for the use of Health Impact Assessments to evaluate the impact of policy on health and health inequalities.
2. Implement actions required for the HSE to ensure that equality is embedded in its services in line with the requirements of the Public Sector Equality and Human Rights Duty.
3. Enable every child to have the best start in life and build a foundation for lifelong health and wellbeing by addressing the commercial and social determinants of health for children.
4. Call for a cross-governmental health inequalities strategy, support the development of future governmental health inequalities work and advocate for an independent health inequalities performance monitoring framework.
5. Ensure that policies to address climate change consider health inequalities.

Measurement and monitoring

1. Agree and implement the use of equity stratifiers with health and social care partners to enable the systematic identification and reporting of inequalities from routinely collected data and ensure the measurement of health inequalities is considered in all future HSE data collection.
2. Progress work on data linkage to improve reporting of health inequalities, including linking data reflecting the SDHs.
3. Work with academic, community and voluntary sector partners to enable qualitative and quantitative data collection and research where gaps in data exist.
4. Advocate across government, including within local authorities, for the collection and reporting of data reflecting the wider determinants of health disaggregated by appropriate equity stratifiers.
5. Publish an annual HSE health inequalities report, including data on healthcare access and health outcomes.

Communities and settings

1. Enable meaningful partnerships, especially with underserved communities. Allow for representative inclusion of citizens, including children and young people, in health needs assessments and in the co-design, delivery and evaluation of services and interventions that affect them (nationally, regionally and locally).
2. Support the further development, evaluation and improvement of place-based initiatives to reduce health inequalities such as Sláintecare Healthy Communities.
3. Develop more formal networks of organisations from academia, community and voluntary sectors, and healthcare to advocate for action on health inequalities.

Access and healthcare

1. Promote both rights-based approaches to advocate for fundamental human needs such as shelter, food and education, and approaches which promote action on the social determinants of health.
2. Advocate for universal healthcare with equitable access to health and social care for all based on need, and trauma-informed policies to create safer, more inclusive services.
3. Plan care recognising population strengths and preferences and focussing on needs, especially on the additional health needs of deprived and socially marginalised communities. Equity should be included in population based planning and all health needs assessments.
4. Collaborate with existing clinical programmes and healthcare settings to develop evidence-informed approaches that ensure health equity is systematically addressed within the HSE.
5. Advocate for technological developments to address difficulties with access, while recognising the difficulties for some groups in using these technologies and risk of digital exclusion.

Evidence, quality and action

1. Produce a strategic plan and training resources aimed at increasing the capacity for action on health inequalities across the health system and beyond.
2. Identify specific health inequalities research priorities as a basis for future partnership working with communities, academic institutions and other organisations.
3. Strengthen international research collaboration to gain additional insights into the impacts of policies and interventions which may be relevant to Ireland, and for trends identified in other countries.
4. Formalise toolkits for health equity audit, health equity assessment and health impact assessment within the HSE.
5. Engage with communities, community organisations and other stakeholders to co-develop frameworks for evidence-based action on health inequalities, building on existing good practice.
6. Expand the number of longitudinal studies conducted in Ireland, with data collected which can be used to detect emerging health inequality trends.

Leadership and communication

1. Embed health equity as strategic priority into all future corporate and operational planning within the HSE alongside equity performance indicators.
2. Develop clear national and regional structures and processes to support health equity work with adequate resourcing.
3. Explicitly address gender bias, stigma, discrimination and racism, raise awareness of their impacts on health outcomes with all staff, and provide training to promote equality and inclusion and culturally appropriate and safe services.
4. Develop dedicated strategies to address specific dimensions of inequality which the HSE can impact directly or in partnership with others.

Introduction

> *“Thus we have a steady increase in the death-rate from its lowest point – amongst the professional or independent class to its highest point – amongst the street hawkers and casual labourers.” (James Connolly 1915)*

In 1915 James Connolly included publicly available mortality statistics by occupational class in Dublin in “*The Re-Conquest of Ireland”,* showing a social gradient in health outcomes where the higher one’s social position, the better one’s health is likely to be, and the lower one’s social position is, the worse their health (8). Since then while the risk factors and aetiologies of disease that contribute to socio-economic health inequalities have changed, the social gradient persists despite significant social and economic development. The Economic and Social Research Institute Report “*Unequal Chances? Inequalities in mortality in Ireland”*, published in 2022, reported those in the lowest occupational class in Ireland had a standardised mortality rate of 1,615 per 100,000, compared with 625 for the highest class (2018 data) (9).

Not all health inequalities are phenomena which can be measured across a gradient; some, such as those experienced by Irish Travellers or individuals with disabilities, are categorical and demand distinct analytical approaches. The All Ireland Traveller Health Study (2010) reported male Traveller life expectancy was 15.1 years lower than the general population and female Traveller life expectancy was 11.5 years lower (7). Life expectancy differences in these groups highlight the need for dedicated interventions.

In an Irish context groups who are socially marginalised or excluded have worse health outcomes. This includes but is not limited to Irish Travellers, Roma, vulnerable migrants, people with disabilities, people with severe and enduring mental illness, sex workers, people with addiction, people in contact with the justice system and people experiencing homelessness. There is compelling evidence of health inequalities for many other social groups, some referenced in Table 1. Additionally, dimensions of inequality may interact resulting in compounding, intersectional effects. For example, single mothers are significantly more likely than partnered mothers to experience depression, anxiety, and to live in inadequate housing conditions, including exposure to damp (10).

Table 1. Examples of health inequalities reported in Ireland by dimension

Dimension	Health inequality	Publisher (year)
Disability	- People living with a disability had a standardised death rate more than four times that of those without a disability (11).	CSO* (2019)
Ethnicity	- Between 1.5 and 2 times higher risk of perinatal mortality for children of African-born mothers compared with Irish born mothers (9).	ESRI* (2022)
Gender	- Women are more likely than men to suffer from worse mental health as a result of caregiving responsibilities, particularly for older relatives or children (12).	NWCI* (2020)
Gender	- 1 in 3 trans adults wait at least three years for a first appointment for specialised care (13).	Belong To (2024)
Gender	- 26% of women surveyed in Ireland had experienced physical and/or sexual violence by a partner or non-partner by the age of 15.	NWCI (2019)
Homeless	- Rough sleepers in Dublin reported to have an average age of death of 42 years for men and 38 years for women (14).	TCD*(2018)
Housing tenure	- Private renters on average report worse health and greater incidence of chronic illnesses compared to homeowners (15).	ESRI* (2023)
Sexual orientation	- LGBTQ+ individuals in Ireland experience higher incidences of mental anxiety and suicidal ideation (16).	Belong To (2024)
Socio-economic status	- Male life expectancy was 5 years less for those in the most deprived quintile compared to the most affluent quintile, female life expectancy was 4.3 years less (11).	CSO* (2019)

**CSO – Central Statistics Office; ESRI – Economic and Social Research Institute; NWCI – National Women's Council of Ireland; TCD – Trinity College Dublin*

Common to all groups who experience health inequalities is the relative lack of economic and cultural resources and power, which allows for the conditions that result in worse health outcomes to continue. Since 2008, when the WHO Commission on the Social Determinants of Health published their report *“Closing the gap in a generation”*, consensus has framed health inequalities as being driven by social inequalities (17,18). This context helps our understanding of the important role inequalities associated with downstream (closer to the individual) determinants of health play and why a social gradient persists in patterns of risk behaviours such as smoking and physical activity.

Inequalities in access to healthcare are a prominent feature of the Irish healthcare system, with a two-tier system of private and publicly funded healthcare and the financial burden of out of pocket payments for many, among other barriers (19). This type of health inequality is often described with reference to the Inverse Care Law, as described by Dr Julian Tudor Hart (20):

> *“The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.”*

Health inequalities have broader societal impacts, beyond their direct impacts on individuals, with inequalities in health affecting all sectors of society.

Policy

Key Points

- Existing Irish government policy emphasises the need to reduce health inequalities.
- A life course understanding of health, and of health inequalities, can allow for dedicated policy action including a focus on the early years to maximise the lifelong health and wellbeing of our population.
- A "Health in All Policies" approach recognises that policies across national and local government influence health inequalities.
- The Public Sector Equality and Human Rights Duty provides a legislative requirement for public services to assess, address and report on inequalities.

Health inequalities are shaped by policy decisions across the life course, influencing not only healthcare but also the broader social and structural determinants of health, such as housing and social welfare. Existing government policy in Ireland has emphasised the importance of tackling health inequalities. Within the *Sláintecare Action Plan for 2023*, one of the two priority reform programmes is to address health inequalities *bringing us on a journey towards Universal Health Care* (21). The second of the four goals of the *Healthy Ireland Framework 2013-2025* is to reduce health inequalities (2).

Childhood is a critical period of development, during which the effects of policy can have long-lasting impacts. In Ireland, this importance is underscored by rising levels of child poverty over the past decade and record numbers of children experiencing homelessness (22). Recognising these challenges, the government has introduced *First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028*, which identifies five key action areas aimed at reducing childhood poverty and addressing its far-reaching consequences (23). Focused actions in later childhood and adolescence are also essential to ensure improved population health.

Other strategies in Ireland focus on the needs of specific populations who experience health inequalities. The *Roadmap for Social Inclusion 2020 - 2025: Ambition, Goals and Commitments* is the government's strategy on poverty reduction (24). It acknowledges the definition of poverty put forward by the European Platform Against Poverty initiative, that *poverty in its multiple dimensions includes a lack of income and sufficient material resources to live in dignity; inadequate access to basic services, such as healthcare, housing and education; labour market exclusion and poor quality work.* Some other relevant policies include the *National Traveller Health Action Plan (2022-2027)*, the *Second National Intercultural Health Strategy 2018-2023*, the *National Traveller and Roma Inclusion Strategy II 2024-2028 (NTRIS II)* and the *National LGBTI Inclusion Strategy 2019-2021* (25–28).

While Ireland does not have an overarching health inequalities strategy, health inequalities are heavily influenced by policies across government, both nationally and regionally. The WHO *Health in All Policies* (HiAP) approach recognises that population health is mostly determined by policies that guide actions outside the health sector (29). Policy in every sector, from housing and education to finance and justice, shapes health outcomes. Health Impact Assessment (HIA) is a process to determine the impact of proposed policies and plans on the health of communities to ensure they are more inclusive, equitable and sustainable (30). Integrating HIA into policy proposals can ensure these cross-sectoral effects are proactively addressed.

There is a requirement in law (a *duty*) for public bodies (the *public sector*), including the health service, to actively promote equality, prevent discrimination, and protect the human rights of their employees, customers, service users and everyone affected by their policies and plans (31). The Public Sector Equality and Human Rights Duty in Section 42 of the Irish Human Rights and Equality Commission Act 2014, outlines this requirement to assess, address and report on relevant actions. This has implications for the publicly funded and provided health and social care services. The *National Standards for Safer Better Healthcare* provide a roadmap for improving the quality, safety and reliability of healthcare, including addressing equity (32).

There is growing international evidence which demonstrates the return on investment for interventions to improve population health and address inequalities is substantial, particularly for early years investment (33). The economic case for action on the wider determinants of health is stronger than ever, along with building a 'wellbeing economy' which values and monitors what really matters for people to flourish (34,35)

Recommendations for action on policy

1. Provide consistent systematic Public Health input into policy at national and regional levels. This includes adopting robust processes for the use of Health Impact Assessments to evaluate the impact of policy on health and health inequalities.
2. Implement actions required for the HSE to ensure that equality is embedded in its services in line with the requirements of the Public Sector Equality and Human Rights Duty.
3. Enable every child to have the best start in life and build a foundation for lifelong health and wellbeing by addressing the commercial and social determinants of health for children.
4. Call for a cross-governmental health inequalities strategy, support the development of future governmental health inequalities work and advocate for an independent health inequalities performance monitoring framework.
5. Ensure that policies to address climate change consider health inequalities.

Measurement and monitoring

Key Points

- Data and reporting on health inequalities need to focus on ‘measuring what matters’ for action.
- Routinely collected and reported health data does not easily allow for the identification and monitoring of health inequalities, and there are significant gaps in data availability.
- Embedding equity stratifiers into data collection will improve our ability to report on health inequalities and assess the effectiveness of interventions aimed at reducing them.
- Linking data has the potential to improve our understanding of health inequalities and the relationships between health outcomes and the SDHs.
- Research, including qualitative research, plays an important role in advancing our knowledge of health inequalities in Ireland.

Currently, the routine reporting of health outcomes in Ireland at a population level including morbidity and mortality does not often disaggregate data to allow for the systematic identification, assessment and monitoring of health inequalities. For example, the Healthy Ireland Outcomes Framework Indicator Set includes 44 indicators, inclusive of both health outcomes and determinants of health (36). However, in the main indicators available do not enable disaggregation by the characteristics required to report on health inequalities.

Efforts to improve the ability to incorporate the reporting of health inequalities into routine datasets include the adoption of small area measures that can use geocoding to assign a score, such as one from the HP Deprivation Index, to an individual based on their place of residence. The HP Index is a composite area level measure of socio-economic status (SES) that uses census data relating to three dimensions of area SES including the demographic profile, social class and labour market situation (37). It has been adopted by several government departments and state agencies, and is available within Health Atlas.

Small area measures are not always appropriate and there is a need to consider the specific population groups affected by a health inequality within a social context. The term “equity stratifiers”, also known as “dimensions of inequality”, is used to describe how we group populations to measure inequalities (38). While not entirely comprehensive, commonly referenced equity stratifiers are summarised in the acronym PROGRESS-PLUS[9].

The incorporation of indicators that can be broken down by appropriate equity stratifiers into routine health-related datasets, and datasets reflecting the wider determinants of health, would transform the understanding of health inequalities in Ireland and allow for Public Health and others to systematically address them in an evidence-informed way.

Data linkage is a technique that allows a connection between databases from different provenances to expand and amplify the information that would be available if the datasets were to be used in isolation. It can play a critical role in reducing health inequalities by providing greater insight into the understanding of health outcomes and the SDHs.

For example, the linkage of healthcare records with Census data could help to identify communities that have been socially marginalised or who suffer unequal health outcomes. This approach can also be used to track outcomes over time, helping to bring to light patterns that may indicate or predict emerging inequalities. Data linkage can also identify where interventions can best be delivered and can be used to assess the impact of health policies and interventions.

Data gaps will continue to persist in Ireland since routine datasets inevitably miss or overlook some measures of inequality. It is therefore also important for Public Health to actively engage with communities and academic partners to identify unmeasured inequalities and support the use of formal research and qualitative methods for describing health inequalities where appropriate.

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[9] PROGRESS stands for Place of residence, Race (or ethnicity), Occupation, Gender (or sex), Religion, Education, Socioeconomic status and Social capital. The PLUS suffix includes personal characteristics, relationship features and time-specific stratifiers such as age, disability and sexual orientation.

Recommendations for action on measurement and monitoring

1. Agree and implement the use of equity stratifiers with health and social care partners to enable the systematic identification and reporting of inequalities from routinely collected data and ensure the measurement of health inequalities is considered in all future HSE data collection.
2. Progress work on data linkage to improve reporting of health inequalities, including linking data reflecting the SDHs.
3. Work with academic, community and voluntary sector partners to enable qualitative and quantitative data collection and research where gaps in data exist.
4. Advocate across government, including within local authorities, for the collection and reporting of data reflecting the wider determinants of health disaggregated by appropriate equity stratifiers.
5. Publish an annual HSE health inequalities report, including data on healthcare access and health outcomes.

Communities and settings

Key points

- Community development approaches in Ireland have a long history of addressing the social determinants of health, unmet health needs and inequalities at a local level.
- Working with communities requires trust and relationship-building on an ongoing basis, listening to understand their needs, and formally including them in planning, co-development and decision making *(""nothing about us without us"*).
- Community settings are strongly positioned to facilitate interventions to reduce health inequalities.
- Sláintecare Healthy Communities is an example of a place based initiative that incorporates interventions involving both the HSE and local authorities.

Community work, or community development, can be defined as "social change to achieve equality, social justice and human rights", and community development approaches to addressing the SDHs are well developed in Ireland (39). While community work addressing determinants of health and health behaviours may not always be expressed in the language of health inequalities, in the past there have been attempts to align local action with community health inequality networks (40). Local and regional actions can also focus on specific determinants, risk factors or settings, and reflect needs identified by the population. For example Local and Regional Drugs and Alcohol Task Forces target drug and alcohol misuse which causes harm across the life course. In care environments where substance misuse occurs, serious damage can affect children at every age and have lifelong impacts.

Effective community collaboration requires not only understanding community needs but also co-creating solutions through inclusive processes, such as participatory action research, citizen panels, and localised health impact assessments. This is particularly important for communities that have been marginalised. These methods help to ensure interventions are contextually relevant and sustainable, fostering long-term trust and engagement. In Ireland, an example of this approach are the Primary Healthcare for Traveller Projects (PHCTPs), a partnership with Traveller communities through culturally sensitive programmes and community development initiatives (41).

Settings based approaches to reducing health inequalities benefit from having a defined target population. Examples of settings which can be considered for interventions include education, workplaces, healthcare, prisons and places of detention, sporting organisations, places of worship and online networks (42) Interventions can enable approaches that address health inequalities without requiring the identification of specific risk groups, and thereby avoid the exclusion of individuals or groups who may not initially be recognised as at risk. Examples include school nutrition programmes and community engagement initiatives, such as Men's Sheds (43).

Place based initiatives (PBI), also referred to as interventions, approaches and partnerships, are collaborative community focused strategies that aim to improve health outcomes in a defined geographic area, recognising that health is influenced by the social, economic and environmental factors specific to the place (44). The Sláintecare Healthy Communities Programme is a PBI which involves leadership from both HSE Health and Wellbeing and from local authorities, focused initially on 19 areas identified as having significant levels of deprivation (45). Supports provided to these areas include various health promotion interventions overseen by the HSE and interventions led by local coordinators integrated into the work of Local Community Development Committees (LCDCs)[10]. Planned evaluations of the programme have been funded and will be conducted over the coming years.

Engaging and working alongside people with lived experience of health inequalities is fundamental to both understanding and developing solutions which can prevent or mitigate worse health outcomes. Processes that empower social participation in interventions to reduce health inequalities and assessing health needs and assets need to be further developed, for example building on the Social Inclusion and Community Activation Programme (SICAP) 2024-2028 which provides funding to address poverty and social exclusion at a local level through local engagement and partnerships between disadvantaged individuals, community organisations and public sector agencies.

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[10] Department of Rural and Community Development. Local Community Development Committees (LCDCs)

Recommendations for action on communities and settings

1. Enable meaningful partnerships, especially with underserved communities. Allow for representative inclusion of citizens, including children and young people, in health needs assessments and in the co-design, delivery and evaluation of services and interventions that affect them (nationally, regionally and locally).
2. Support the further development, evaluation and improvement of place-based initiatives to reduce health inequalities such as Sláintecare Healthy Communities.
3. Develop more formal networks of organisations from academia, community and voluntary sectors, and healthcare to advocate for action on health inequalities.

Access and healthcare

Key Points

- Access to basic needs like housing, food, and education are human rights and key social determinants of health.
- Healthcare access is a complex concept that includes the availability, affordability, and acceptability of services and the capabilities of users and communities.
- Ireland's two-tier healthcare system creates healthcare inequalities, where access to private health insurance enables more timely access to healthcare, reducing waiting times and potentially harmful delays.
- Recent examples have shown that service areas within the HSE can lead on assessing and addressing health inequalities.

While access to adequate housing, nutritious food, and quality education are fundamental rights, many people in Ireland remain without basic needs essential to achieving the highest attainable standard of health and wellbeing (46). Deprivation of these basic needs is not equally felt by all and is patterned by relations of gender, ethnicity and social class. HSE Public Health has a commitment to act to improve the lives of those groups who experience deprivation consistently, including supporting ongoing work addressing child poverty and advocacy for the delivery of public services in line with the principles of proportionate universalism (or progressive universalism) where appropriate[11].

Timely and equitable access to effective, safe and people-centred integrated healthcare is an integral part of any health system aiming to reduce health gaps and inequity. A key component of quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health and wellbeing outcomes. Access is a complex concept that includes use of healthcare services, availability, accessibility, accommodation, affordability and acceptability (49).

Improving equitable access (equal access for equal need) requires consideration

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[11] 'Progressive universalism' approaches include a "determination to include people who are poor from the beginning"(47). 'Proportionate universalism' approaches are defined as "the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need"(48).

of service user abilities alongside service provision characteristics. Services have a responsibility to create environments which enable all users to use healthcare. Inequalities can be introduced if differences exist in ability or capacity for people to use services. For example, in recent years this has been noted of trends to adopt digital technologies to access healthcare (digital exclusion).

Sláintecare aims to improve access for all, while currently Ireland has a ‘two-tier’ public and private healthcare system (4). The public health care system is available to all residents but not free at the point of use to everyone. Many people have private health insurance that provides access to private hospitals. Other inequalities to access are associated with staffing deficits and long waiting times for public patients for disability assessments, outpatient appointments, elective surgery, home care and access to radiology which can be bypassed for patients with private healthcare (50). Inequalities in access to GP and primary care services are different to those affecting hospital medicine, stemming from issues of affordability and availability linked to a shortage of GPs across the country (51).

In contrast to the current unequal distribution of all healthcare, resource allocation should be based on health needs, not simply the size of the population or the market available. Health needs refer to those that can be identified from current service demand, as well as needs that are felt but unmet and not measured routinely. A new Population Based Resource Allocation (PBRA) formula developed by the Department of Health to be implemented across the HSE Health Regions, aims to distribute resources according to population health needs to promote efficiency and equity (52). The HSE Population Based Planning Programme’s role is to embed an integrated and comprehensive approach to assessing population health needs, preferences and assets into national, regional and local planning and resource allocation. It takes account of health outcomes and wider determinants of health.

At an organisational level, services can demonstrate leadership in identifying and addressing health inequalities as they pertain to their area of work. In an Irish context examples include: the National Screening Service’s recently published equity strategy entitled *“Improving equity in screening: A strategic framework 2023-2027”* (34), the work of the National Social Inclusion Office and regional Social Inclusion teams in the HSE, the development in acute hospitals of Inclusion Health Services and Teams supporting the needs of population groups that have been underserved, and Deep End Ireland providing primary care services in disadvantaged areas (53). HSE Public Health is working with National Clinical Programmes to embed a population health approach in clinical design, with explicit focus on addressing equity and social determinants of health in design of models of care.

There is increasing recognition of the roles of Adverse Childhood Experiences (ACE) and trauma on individual and population health, and the need for trauma-informed policies and practices to create safer, more inclusive services.

Recommendations for access and healthcare

1. Promote both rights-based approaches to advocate for fundamental human needs such as shelter, food and education, and approaches which promote action on the social determinants of health.
2. Advocate for universal healthcare with equitable access to health and social care for all based on need, and trauma-informed policies to create safer, more inclusive services.
3. Plan care recognising population strengths and preferences and focussing on needs, especially on the additional health needs of deprived and socially marginalised communities. Equity should be included in population based planning and all health needs assessments.
4. Collaborate with existing clinical programmes and healthcare settings to develop evidence-informed approaches that ensure health equity is systematically addressed within the HSE.
5. Advocate for technological developments to address difficulties with access, while recognising the difficulties for some groups in using these technologies and risk of digital exclusion.

Evidence, quality and action

Key Points

- Building capacity to address health inequalities requires a multi-disciplinary team approach across organisations.
- Collaboration and partnership working with academic institutions and non-governmental organisations (NGOs) is essential to better understand health inequalities and potential effective interventions.
- Health equity audits and health equity assessments can help identify at-risk populations, quantify health impacts, and provide a basis for action.
- HSE Public Health requires systematic approaches for action to reduce health inequalities.

Building capacity to meaningfully impact health inequalities at national and regional levels requires adopting a multi-disciplinary team working across organisations. From a HSE Public Health perspective it includes promoting existing materials developed by the National Social Inclusion Office (see Appendix B) and the National Office for Human Rights and Equality Policy, and developing new training resources for healthcare workers, professionals working across government, community and voluntary organisations, and for the public. These resources must include information that is culturally sensitive, with a focus on anti-discrimination and equity. Developing such a workforce has resource considerations and a need to consider appropriate funding opportunities with partners.

Research published by academic and non-governmental institutions has been key to developing an understanding of health inequalities in Ireland. HSE Public Health partnering on programmes of research will help to add to the evidence based for the causes and effects of health inequalities, and to inform the interventions needed to reduce them in an Irish context. In addition, international collaboration can provide learning and evidence for action, along with highlighting emerging health inequality concerns, such as demographic changes, climate change, and digital inequalities.

Before communities or services agree on specific plans to reduce health inequalities, there are tools that can help define the aim of any intervention. Tools such "Health Equity Audit" and "Health Equity Assessment" can consider populations at risk of a health inequality, quantify the health impact and seek to understand the specific causal pathways involved (54,55). Their adoption has the potential to act as a framework to help local communities, service providers, and policy makers to identify and address health inequalities. Likewise, the use of HIAs can highlight equity concerns in national and local policy at a stage where they can be addressed before implementation (56,57) .

Along with a more complete understanding of the causes of health inequalities in Ireland there is a need for HSE Public Health to develop evidence informed approaches to address them, whether they focus on specific populations, aim to act on a social gradient or a combination of both (58).

Recommendations for evidence, quality and action

1. Produce a strategic plan and training resources aimed at increasing the capacity for action on health inequalities across the health system and beyond.
2. Identify specific health inequalities research priorities as a basis for future partnership working with communities, academic institutions and other organisations.
3. Strengthen international research collaboration to gain additional insights into the impacts of policies and interventions which may be relevant to Ireland, and for trends identified in other countries.
4. Formalise toolkits for health equity audit, health equity assessment and health impact assessment within the HSE.
5. Engage with communities, community organisations and other stakeholders to co-develop frameworks for evidence-based action on health inequalities, building on existing good practice.
6. Expand the number of longitudinal studies conducted in Ireland, with data collected which can be used to detect emerging health inequality trends.

Leadership and communication

Key Points

- Addressing health equity requires leadership at societal and organisational levels to achieve change.
- Public health leaders must integrate action on the social determinants of health into their strategies, using data, collaboration, and communication to influence others.
- Raising public awareness, building capacity and trust, fostering collaboration, and empowering communities are key actions to promote health equity.

Most national public health agencies now include a commitment to addressing health equity with both universal approaches and targeted actions outlined in strategies and action plans (59). This ensures that broad, inclusive solutions are promoted that may help to prevent health inequalities from developing while also ensuring that focused interventions are deployed to address inequalities that have already developed. Tackling health inequalities and achieving true health equity needs societal, organisational and individual leadership that integrates science, practice, and policy to create lasting and sustainable change (60).

To be effective, public health leaders must cultivate a broad vision that incorporates addressing the social determinants of health into their day-to-day work and their strategies, as well as advocating for non-health sector factors that impact on health inequalities, for example, influencing policy on housing, and on green and blue spaces. This should include advocacy for investment across all sectors to address the social and commercial determinants of health, including children in their early years to ensure that every child is given the best start in life. They need to communicate effectively to build trust and relationships, to influence and motivate stakeholders, to collaborate within and across sectors. They also need to use data to monitor health outcomes, inform action and ensure accountability in addressing inequalities (61).

The main principles of action towards health equity recommended in the WHO

Commission on Social Determinants of Health include raising public awareness, increasing knowledge, and developing a trained workforce, underpinned by the principles of participation, justice, and collaboration. Raising awareness and capacity building require a coordinated approach to ensure the public, healthcare providers, policy makers, and wider partners are equipped with the relevant knowledge, skills, and resources required to promote equitable health and wellbeing outcomes across communities and populations.

By raising awareness, building capacity, fostering collaboration and co-development, building trust and relationships, empowering communities, and investing in research, the HSE can create a more just and equitable health system.

Recommendations for leadership and communication

1. Embed health equity as strategic priority into all future corporate and operational planning within the HSE alongside equity performance indicators.
2. Develop clear national and regional structures and processes to support health equity work with adequate resourcing.
3. Explicitly address gender bias, stigma, discrimination and racism, raise awareness of their impacts on health outcomes with all staff, and provide training to promote equality and inclusion and culturally appropriate and safe services.
4. Develop dedicated strategies to address specific dimensions of inequality which the HSE can impact directly or in partnership with others.

Conclusion

In 2025, health inequalities continue to adversely impact on the health of the population of Ireland, evidenced by differences in morbidity and mortality between social groups and across a social gradient. This position paper aims to be both a guide and stimulus for action for those working in HSE Public Health.

There are concrete steps which could transform our ability to effectively reduce health inequalities, in relation to health policy, measurement or community action. But action also requires evidence and leadership, and principles which ensure partnership working is embedded and explicit in future work. Commitment to these principles and working together to narrow the gap in health inequalities will enable everyone regardless of their background or social circumstances, to achieve their highest level of health. Together, we can build a healthier, fairer future for all.

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Appendix A – Working Group Membership

This paper was developed by a working group within the HSE chaired by Prof Diarmuid O'Donovan and Dr Lorraine Doherty. The preparation of the paper was led by Dr Chris Carroll. Membership of the working group included:

HSE area	Name/ Role
Public Health (Centre)	Office of the National Director of Public Health: Lorraine Doherty (**Co-Chair**) Health Improvement: Diarmuid O'Donovan, Director (**Co-Chair**), Chris Carroll, CPHM; Claire Neill, CPHM; Gregory Martin, CPHM; Sara Hamdona Child Health Public Health: Fiona Cianci, CPHM Health Intelligence: Declan McKeown, CPHM Health Protection: Keith Ian Quintyne, CPHM Health Service Improvement: Aileen Kitching, CPHM si Health Inequalities–Social Inclusion National Cancer Control Programme: Breeda Neville, CPHM National Screening Service: Laura Heavey, CPHM
Public Health (Regions)	HSE Dublin and North East: HSE Dublin and Midlands: Fionnuala Cooney, Regional DPH; Una Fallon, CPHM si Health Improvement HSE Dublin and South East: Catherine Lynch, CPHM si Health Improvement HSE South West: Peter Barrett, CPHM si Health Intelligence HSE Mid West: Anne Dee, CPHM si Health Improvement HSE West and Northwest: Mark O'Loughlin, CPHM si Health Intelligence
Public Health SpRs:	James O'Connell; Therese McGlacken; Maria Deery
Access & Integration (Centre)	Wellbeing, Equality, Climate & Global Health: Philip Crowley, National Director; Helen Deely, AND H&WB National Office for Equality & Human Rights: Caoimhe Gleeson, Jacqueline Grogan National Social Inclusion Office: Aileen Kitching, CPHM si Health Inequalities–Social Inclusion

Appendix B – National Social Inclusion Office HSELand Training Materials

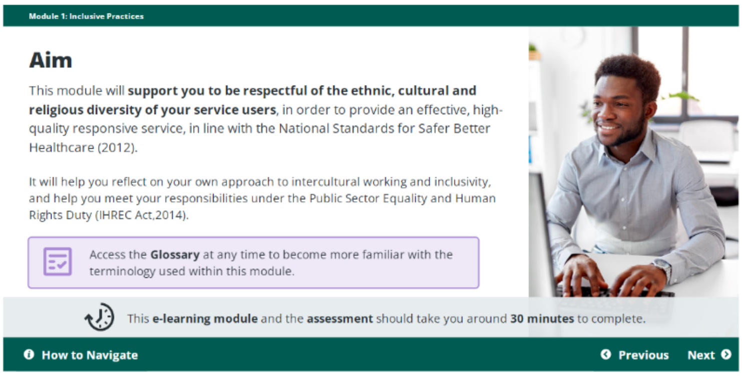
HSE Social Inclusion

TRAINING – for staff working with migrants and Travellers (January 2025)

Training on HSELanD

Intercultural_Awareness_E_Learning_Programme on HSELanD

(a) Inclusive practices and intercultural awareness (30 minutes) will support you to be respectful of the ethnic, cultural and religious diversity of service users, in order to provide an effective, high quality responsive service.



Module 1: Inclusive Practices

Aim

This module will **support you to be respectful of the ethnic, cultural and religious diversity of your service users**, in order to provide an effective, high-quality responsive service, in line with the National Standards for Safer Better Healthcare (2012).

It will help you reflect on your own approach to intercultural working and inclusivity, and help you meet your responsibilities under the Public Sector Equality and Human Rights Duty (IHREC Act,2014).

Access the **Glossary** at any time to become more familiar with the terminology used within this module.

This **e-learning module** and the **assessment** should take you around **30 minutes** to complete.

(b) Working with others (30 minutes) will enhance your ability to provide a culturally sensitive service by using techniques that have been shown to reduce the potential harm that unconscious bias may have on our service users.

(c) Refugees, protection applicants and trauma (45 minutes) will support you to work with refugees and protection applicants so as to improve their health outcomes. It will also help you to recognise trauma reactions and take some steps to avoid triggering or re-traumatising service users.

(d) Understanding migrant mental health and wellbeing (30 minutes) will help you provide a compassionate and person-centred response when working with people from migrant communities, and to signpost them to mental health and wellbeing supports if, and when, it is appropriate.

All four modules have been approved by the Nursing and Midwifery Board of Ireland (NMBI) for Continuing Education Units (CEUs): Module 1, 2 & 4 (1 CEU each) and Module 3 (3.5 CEUs).

HSE National Domestic, Sexual and Gender Based Violence available on HSELanD

HSE Domestic, Sexual and Gender Based Violence (DSGBV) Programme

Module 1: Awareness

This course contains audio.

Modules 1 & 2 of a 4 module DSGBV training programme are available.

Awareness: Module 1 covers:

- Different types of DSGBV
- Statistics and prevalence about DSGBV
- Facts and myths
- Relevant legislation and policies
- Impact of DSGBV on specific communities

Recognise: Module 2 covers:

- Recognising signs of different types of DSGBV
- Impact of DSGBV on individuals (victims and survivors), children, communities and societies.
- Barriers victims face to seek support from an intersectional lens.

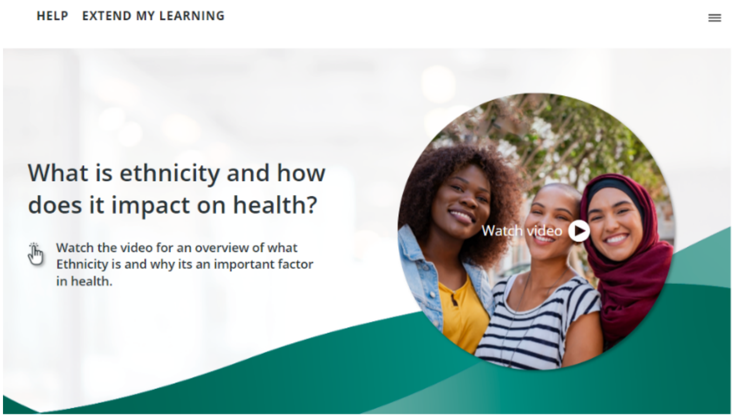
Respond: Module 3 covers provision of tools for professionals to:

- Understand the importance of asking about DSGBV,
- Gain skills on when to ask and how to approach the question,
- Respond and support a victim during and after a disclosure – including risk assessment and safety planning,
- Understand barriers victims may face to disclose abuse

Modules 4 is scheduled to be released soon.
1 CPD hour has been awarded per module in accordance with NMBI guidance.

Introduction to Ethnic Equality Monitoring (EEM) available on HSELanD **(30 mins)**

- The module explains what ethnic equality monitoring is and why it's important in healthcare. After completing the module you will know how to sensitively gather information from clients, what to record and where to get more information.

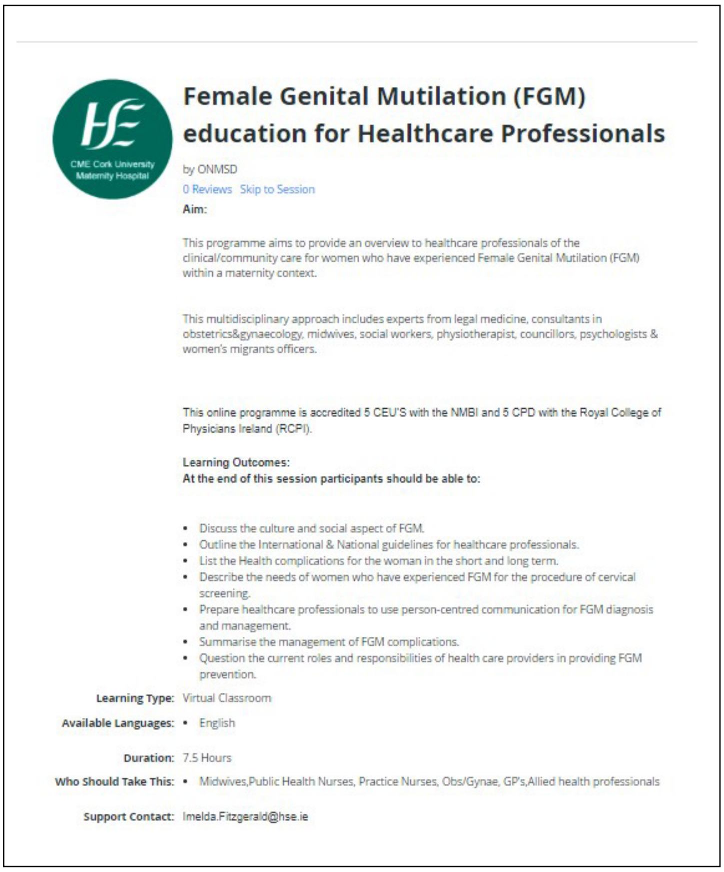


What is ethnicity and how does it impact on health?

Watch the video for an overview of what Ethnicity is and why its an important factor in health.

Female Genital Mutilation (FGM) education for Healthcare Professionals

The FGM session on HSEland is a 7.5 hour course aimed at medical professionals (mostly in maternity settings).



Female Genital Mutilation (FGM) education for Healthcare Professionals

by ONMSD

0 Reviews Skip to Session

Aim:

This programme aims to provide an overview to healthcare professionals of the clinical/community care for women who have experienced Female Genital Mutilation (FGM) within a maternity context.

This multidisciplinary approach includes experts from legal medicine, consultants in obstetrics&gynaecology, midwives, social workers, physiotherapist, councillors, psychologists & women's migrants officers.

This online programme is accredited 5 CEU'S with the NMBI and 5 CPD with the Royal College of Physicians Ireland (RCPI).

Learning Outcomes:
At the end of this session participants should be able to:

- Discuss the culture and social aspect of FGM.
- Outline the International & National guidelines for healthcare professionals.
- List the Health complications for the woman in the short and long term.
- Describe the needs of women who have experienced FGM for the procedure of cervical screening.
- Prepare healthcare professionals to use person-centred communication for FGM diagnosis and management.
- Summarise the management of FGM complications.
- Question the current roles and responsibilities of health care providers in providing FGM prevention.

Learning Type: Virtual Classroom

Available Languages: • English

Duration: 7.5 Hours

Who Should Take This: • Midwives,Public Health Nurses, Practice Nurses, Obs/Gynae, GP's,Allied health professionals

Support Contact: Imelda.Fitzgerald@hse.ie

Human Trafficking Awareness Training

This training has been developed by the HSE National Social Inclusion Office in collaboration with the HSE Anti-Human Trafficking Team.

The aim of this resource is to:

- Improve awareness of Human Trafficking in all its forms.
- Provide information about the national and international policy context and relevant legislation.
- Provide information about the role of the HSE in the context of the new Third National Action plan to Combat Human Trafficking and the revised National Referral Mechanism.
- Build knowledge about the work of the HSE Anti-Human Trafficking Team to support victims

Introduction to Traveller Health available on HSEland

Help staff to respond to the health needs of members of the Irish Traveller Community in order to provide an effective and high quality responsive service. This module will support you to have a greater understanding of factors that influence Traveller health and play your part in providing a more inclusive and culturally competent service to members of the Traveller Community.

Training available online/YouTube

Working with interpreters (April 2024)

(a) Theoretical Framework, Meetings and Challenges (172 min)

Learning aims:

- Understanding theoretical and cultural aspects of working with Interpreter
- How to book, deliver and debrief an initial meeting using an Interpreter
- Troubleshooting common challenges in interpreter work

Recording available: https://youtu.be/HWtqfv-IjNA

Briefing the interpreter

The time you spend briefing will be repaid tenfold! Especially important for therapy sessions and assessments. Briefing should include:

- ✓ Pre-existing relationship?
- ✓ Overview of patient's background and notable features of presentation
- ✓ Purpose, content and duration of the session
- ✓ Clarify terms or concepts
- ✓ How you will handle patient distress
- ✓ How you want them to interpret (first person, consecutive/simultaneous?)
- ✓ Ask them to switch off their phone

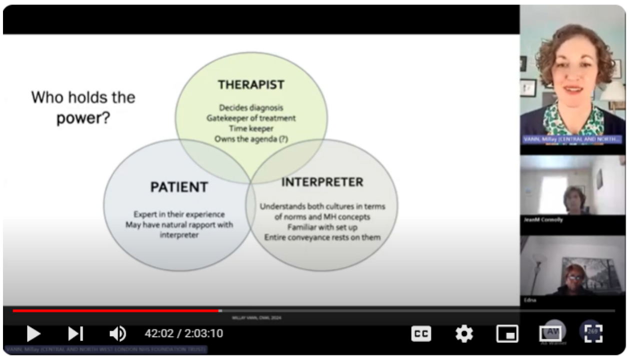
Working With Interpreters Training - Theoretical Framework, Meetings and Challenges

(b) Power Dynamics, Therapeutic Work and Working Remotely (123 min)

Aimed at staff in the HSE and Section 38/Section 39 funded services who carry out assessments and/or therapeutic interventions via an Interpreter as part of their role.

Learning aims:

- Managing power dynamics and boundaries in therapeutic work with Interpreters
- Therapeutic work with Interpreters: evidence base, guidelines and troubleshooting
- Working remotely with Interpreters



Who holds the power?

THERAPIST
Decides diagnosis
Gatekeeper of treatment
Time keeper
Owns the agenda (?)

PATIENT
Expert in their experience
May have natural rapport with interpreter

INTERPRETER
Understands both cultures in terms of norms and MH concepts
Familiar with set up
Entire conveyance rests on them

Working with Interpreters Training - Power Dynamics, Therapeutic Work and Working Remotely

Recording available: https://youtu.be/WElcXmfw6RQ

Facilitator: Millay Vann facilitated both session is a highly experienced trauma-focused Cognitive Behavioural Therapist and Social Worker who has worked at Woodfield Trauma Service for 11 years and now manages the service. Woodfield Trauma Service is a specialist psychology service that offers stepped-care treatment for refugees and asylum seekers with PTSD, and is known nationally and internationally for its expertise in working with the complexities of this population. She also offers training nationally to mental health teams and psychology services on working with refugees and asylum seekers, as well as delivering High-intensity IAPT training on PTSD.

Tips on working with interpreters developed by Cork Kerry Social Inclusion Psychology service.

Working sensitively with migrants who have experienced trauma specifically related to sexual violence and abuse (December 2023)

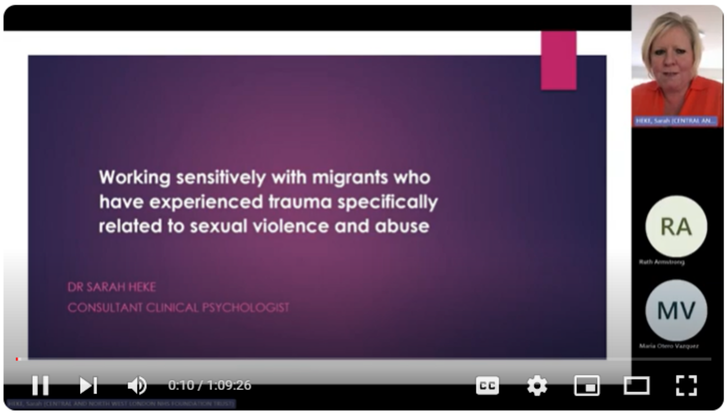
Recording available https://youtu.be/CJLlcnehtwY

Facilitator: Dr. Sarah Heke, Consultant Clinical Psychologist/Lead for Employee Trauma Support. CNWL Centre for Anxiety, Stress and Trauma (CAST), Central and North West London (CNWL) NHS Foundation Trust

Female Genital Mutilation Awareness Training for Social Inclusion Staff.

Training coordinated by HSE National Social Inclusion Office and facilitated by Hope Turner - Migrant Women's Health Officer, AkiDwA and Dr Caitríona Henchion - Medical Director, IFPA.

NSIO with AkiDwA and IFPA for a 1h session on FGM for Social Inclusion Staff. It covers some of the medical aspects (health implications, etc.) but the framework is more SI.



Working sensitively with migrants who have experienced trauma specifically related to sexual violence and abuse

DR SARAH HEKE
CONSULTANT CLINICAL PSYCHOLOGIST

Working sensitively with migrants who have experienced trauma including sexual violence

Available HERE https://youtu.be/VWLZjENk170